TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain & Recovery Clinic - North

Respondent Name
AIG Property Casualty Company

MFDR Tracking Number
M4-16-3332-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 30, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: $3625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on July 8, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14 – 29, 2016	Chronic Pain Management	$3625.00	$3338.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment reasons:
   - Workers' compensation jurisdictional fee schedule adjustment.
   - The charge for the procedure exceeds the amount indicated in the fee schedule.

Issues

1. What is the total allowable reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(h) states:

   (5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.
   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

   The requestor is seeking reimbursement for 6.5 hours for date of service March 14, 2016. Submitted documentation supports 6.25 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a maximum allowable reimbursement (MAR) of $781.25.

   The requestor is seeking reimbursement for 6.5 hours for date of service March 15, 2016. Submitted documentation supports 6.25 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $781.25.

   The requestor is seeking reimbursement for 7 hours for date of service March 16, 2016. Submitted documentation supports 6.75 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $843.75.

   The requestor is seeking reimbursement for 6.5 hours for date of service March 17, 2016. Submitted documentation supports 6.5 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $812.50.

   The requestor is seeking reimbursement for 6.5 hours for date of service March 18, 2016. Submitted documentation supports 6.25 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $781.25.

   The requestor is seeking reimbursement for 7 hours for date of service March 22, 2016. Submitted documentation supports 6.75 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $843.75.

   The requestor is seeking reimbursement for 7 hours for date of service March 29, 2016. Submitted documentation supports 6.75 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $843.75.

2. The total allowable amount for the disputed services is $5588.00. The insurance carrier paid $2250.00. An additional reimbursement of $3338.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3338.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3338.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	October 7, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.